DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G452		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/09/2	ETED	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET A 52812 H	DDRESS, CITY, STATE, ZIP CODE HIGHLAND DR BEND, IN46635		
(X4) ID PREFIX TAG W0000	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0120	Facility Number: 00 Provider Number: 1: AIMS Number: 100: Surveyor: Christine III/QMRP These deficiencies a accordance with 431 Quality Review com Shackelford, Medica The facility must as meet the needs of Based on observa interview, the fact sampled clients (assure active trea provided at day p Findings include: An outside day p conducted on 9/7 until 1:30 P.M workshop area at was observed hur	eptember 7, 8 and 9, 2011. 10966 15G452 1244770 Colon, Medical Surveyor Iso reflect state findings in IAC 1.1. 10pleted 9/16/11 by Ruth 11 Surveyor III. 11 sesure that outside services each client. 12 ation, record review, and 13 cility failed for 2 of 4 clients #1 and #4) to the the three		0120	The issues notted in tthis ttag have been communicatted tto tthe direct of ithe outtside day program and rettraining will be conductted with sttafi att tthe day program tto assuse tthatt tthe goals and continuous attreattment is being provided fior people who live att tthe Highland home and attend day program att tthatt fiacility Monthly Active Treattment observations will be done by tthe Dungarvin QMRP or Lead Counseld tto assure tthatt tthese expectiation being mett Systtem wide all Program	cttor h tthe ure cttve all	10/09/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YTCY11

Facility ID:

000966

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC STREET ADDRESS, CITY, STATE, ZIP CODE 52812 HIGHLAND DR SOUTH BEND, IN46635 (X4) ID PROVIDERS PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G452		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/09/2	LETED	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) TAG PREFIX COMPLETIC (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Until 1:00 P.M., client #1 was observed Directto/QMRP's will review tthis				B. WIN	52812 H	HIGHLAND DR	<u> </u>	
	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	E	COMPLETION
sitting on the table. Client #1 sat during the entire observation with no activity or staff interaction while the one staff assigned to the room ate lunch. From 1:00 P.M. until 1:30 P.M., client #4 was observed hunched over with his head laying in his lap asleep. During the entire observation period client #4 was observed with no activity or staff interaction. A review of client #1's day program record was conducted on 9/8/11 at 10:49 A.M A review of client #1's Day Program goal sheet dated 9/1/11 indicated: "Will put her lunch bag up on the coat rack after eating lunchwill wash her hands." An interview with day program staff #1 was conducted on 9/7/11 at 1:00 P.M Day program staff #1 indicated client #1 ate lunch at 11:00 A.M An interview with the Lead Counselor (LC) was conducted on 9/8/11 at 2:01 P.M The LC indicated clients #1 and #4 should be provided active treatment at day program. 1.1-3-1(a)		until 1:00 P.M., of sitting at a table of sitting on the table the entire observed staff interaction of assigned to the result of the entire observed hunched laying in his lapse observation period with no activity of the record was conducted of the entire observed hunched laying in his lapse observation period with no activity of the entire of the entire of the entire observation period with no activity of the entire observation period with no activity of the entire observation period was conducted of the entire observation period with no activity of the entire observation period with no activity of the entire observation period was conducted or the entire observation program start at a lunch at 11:00. An interview with (LC) was conducted or program.	client #1 was observed with her empty lunch bag le. Client #1 sat during ation with no activity or while the one staff bom ate lunch. From :30 P.M., client #4 was d over with his head asleep. During the entire od client #4 was observed or staff interaction. at #1's day program acted on 9/8/11 at 10:49 of client #1's Day eet dated 9/1/11 put her lunch bag up on er eating lunchwill wash th day program staff #1 n 9/7/11 at 1:00 P.M ff #1 indicated client #1 0 A.M th the Lead Counselor eted on 9/8/11 at 2:01 dicated clients #1 and #4			sttandard and assure tthatt tthi concern is being addressed att Dungarvin ICF-MR's. Persons Responsible: Program Director /QMI Day Program Staff, Lea	s all RP ,	

AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G452 NAME OF PROVIDER OR SUPPLIER			ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE HIGHLAND DR	09/09/2	LETED
DUNGA	RVIN INDIANA LLC			BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
W0248	made available to staff of other ager client, and to the a minor) or legal grassed on observinterview, the fa updated Individual for 1 of 4 sample available for all day program. Findings included An observation was conducted or until 1:30 P.M 1:00 P.M., client with no activity. Client #1's record at 12:10 P.M. Record indicated review. No furth available for review. No furth available for review current ISP dates for staff who word day program. An interview with was conducted or Day program #2	ation, record review and cility failed to have all Support Plans (ISP) ed clients (client #1), staff who worked at the extra the outside day program on 9/7/11 from 11:40 A.M. From 11:45 P.M. until at #1 was observed sitting	W0248	W248 483.440 Individual Pr Plan The Program Directto/QMRP verified tthatt tthe day prograindividuals att tthe Highland have received copies ofi tthe IPP's. Going fiorward tthe QI assure tthatt tthese IPP's are tthe day program provider viso we have an electtronic ver tthatt tthose were sentt tto tt service providers. Montthly Treattmentt observattons will by tthe Dungarvin QMRP or I Counselor tto assure tthatt tt are in place. Systtem wide all Program Directto/QMRP's will review sttandard and assure tthatt tt concern is being addressed a Dungarvin ICF-MR's. Persons Responsible Program Director /QM	has am fior all home annual MRP will sentt tto a email rificatton the day Active I be done ead he IPP's tthis this this	10/09/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15G452	B. WIN			09/09/2	011
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			52812 F	HIGHLAND DR		
	RVIN INDIANA LLC		_		BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	COMPLETION DATE
IAU	REGULATORT OR	ESC IDENTIFY INCHINFORMATION)		IAG	2-2-10-2-17		DATE
W0369	(LC) was conducted P.M The LC in had been updated should have the colient #1. 1.1-3-4(a) The system for drassure that all druself-administered, error. Based on observatinterview, the facts sampled clients (the the Lead Counselor eted on 9/8/11 at 2:01 andicated the client's ISP and day program staff applicated information for a supply administration must ges, including those that are are administered without action, record review and cility failed for 2 of 4 (clients #1 and #2) to	W	W0369 W 369 483.460 Drug Administiration The sttafi person responsible fior tthe medicatton error has been rettrained on tthe specific concerns notted in tthe survey reportt All sttafi att tthe home has reviewed tthis sttandard as well The Program Directtor fiacilitty nurse and designee's will conductt random		10/09/2011	
		inistered the clients' ordered without error.				ome ell rse om	
	the group home of until 7:30 A.M was observed eat consisted of a bo A.M., client #2 v his Phenytoin 10 capsules for seizing tablet supplement	vation was conducted at on 9/8/11 from 6:20 A.M. At 6:45 A.M., client #1 ting her breakfast which wl of cereal. At 7:00 was observed receiving 0 mg (milligram) ures, his Potassium 10 ment and his Thera M at in a half filled 5 ounce tter. At 7:05 A.M., a	medicatton passing observattons att tthe home witth various sttafi tto ensure consistency in tthe medicatton passing systtem All ICF Program Directtors will review tthis sttandard and assure tthatt tthis issue is being evaluatted as a possible concern in all ICF-MR's. Persons Responsible: Program Directior/QMRP, Facility Nurse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G452	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 09/09/2	LETED
NAME OF PROVIDER OR SUPP		52812 I	ADDRESS, CITY, STATE, ZIP CODI HIGHLAND DR I BEND, IN46635	Ē	
PREFIX (EACH DEFIC TAG REGULATORY	RY STATEMENT OF DEFICIENCIES EIENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION) medication punch card and	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
Medication A 9/11 indicated capsules3 c plenty of wat tablet1 table plenty of wat orally once a At 7:10 A.M. receiving her for acid reflue of the medical Medication A 9/11 indicated capsule1 ca before food/n An interview Practical Nur the facility's a 9/8/11 at 1:10 client #2 shou ounces of wa further indical eaten prior to The LPN furt	dministration Record dated l: "Phenytoin 100 mg apsules every morningwith erPotassium 10 mg et orally once a day with erThera M tablet1 tablet day with plenty of water." , client #1 was observed Omeprazole 20 mg capsules a. At 7:15 A.M., a review tion punch card and dministration Record dated l: "Omeprazole 20 mg psule by mouth dailytake				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	ETED	
		15G452	B. WIN			09/09/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			1	HIGHLAND DR		
DUNGAR	RVIN INDIANA LLC			1	BEND, IN46635		
					, n440000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
W0371	•	ug administration must					
		are taught to administer ons if the interdisciplinary					
		hat self-administration of					
		appropriate objective, and if					
		s not specify otherwise.					
	Based on observa	ation, record review and	l w	0371	W371 483.460(k)(4) Drug		10/09/2011
		f 4 sampled clients			Administiration		
		nd #4), the facility failed			The Program Directto/QMRP fior t	the	
		on objectives in each			Highland home will review tthis		
		al Support Plans (ISPs) to			sttandard and assure tthatt all		
	teach medication	• •			individuals att tthatt home have a		
	teach medication	administration.			learning program in place tto addr	ess	
					tthe need fior independence in selfimedicatton administratton		
	Findings include	:			Goals will be putt in place fior clie	antt'	
					s #1, #2, and #4 tto address tthis	;iitt	
	A morning obser	vation was conducted at			need.		
	the group home of	on 9/8/11 from 6:20 A.M.			All sttafi att tthe Highland home w	ill I	
	until 7:30 A.M	At 6:30 A.M., client #4			review tthese new goals The		
	was observed dur	ring medication			Program Directtor fiacilitty nursear	nd	
		No medication training			designee's will conductt random		
		ring the medication			medicatton passing observattons a	att	
		At 7:00 A.M., client #2			tthe home witth various sttafi tto		
	was observed du	*			ensure consisttency in tthe		
		•			medicatton objecttve		
		No medication training			implementtatton		
		ring the medication			All ICF Program Directtors will revi		
		At 7:10 A.M., client #1			tthis sttandard and assure tthatt tt		
	was observed du	ring medication			issue is being evaluatted as a poss concern in all ICF-MR's.	INIC	
	administration.	No medication training			Persons Responsible: Program		
	was observed du	ring the medication			Directior/QMRP, Facility Nurse		
	administration.				,,,,,		
	A review of clien	nt #1's record was					
		facility's administrative					
		at 10:49 A.M Review					
	of client #1's Info	ormed Consent					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED	
		15G452	5G452 B. WING 09		09/09/2	011		
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>		
NAME OF	PROVIDER OR SUPPLIEF	₹		52812 H	HIGHLAND DR			
	RVIN INDIANA LLC			SOUTH	I BEND, IN46635			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG	 	· · · · · · · · · · · · · · · · · · ·	-	IAG			DAIL	
	the client needed	A) dated 9/29/10 indicated						
	1							
	supervision/instr							
	programming to							
		state the purpose of						
	1	to state side effects of						
	1	ient #1's ISP dated						
		indicate any medication						
	administration of	bjectives.						
	A ravian of clian	nt #2's record was						
		facility's administrative						
	1	at 11:26 A.M Review						
	of client #2's Inf							
	`	A) dated 7/18/11 indicated						
		d staff guidance/reminder						
		ate name of medications,						
	1 ^ ^	ose of medications and to						
	state side effects	of medications. Client						
	#2's ISP dated 7/	/19/11 did not indicate						
	any objectives to	assist the client to learn						
	to self administe	er medication.						
		1 // Al 1						
	1	nt #4's record was						
	1	facility's administrative						
	1	at 12:05 P.M Review of						
	1	ned Consent Assessment						
		11 indicated the client						
	needed staff guid	dance/reminder or						
	prompts to state	name of medications, to						
	state the purpose	e of medications and to						
	state side effects	of medications. Client						
	#4's ISP dated 6/	/9/11 did not indicate any						
		ist the client to learn to						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G452			(X2) MU A. BUIL B. WING	DING	00	(X3) DATE S COMPL 09/09/2	ETED
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		p. with	52812 H	DDRESS, CITY, STATE, ZIP CODE IIGHLAND DR BEND, IN46635			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0460	(LC) and Qualific Professional (QM) the facility's adm 9/8/11 at 2:01 P.I indicated client # Support Plans did their identified not documentation where the specially-prescribe Based on observation for 1 of 4 sample facility failed to a food in accordance Findings include An evening observating observed group home of P.M. until 6:20 P #1 was observed snack. Client #1 a snack of a mechanical professional professional professional professional (Lient #1 a snack of a mechanical professional profess	th the Lead Counselor and Mental Retardation MRP) was conducted at inistrative office on Mr. The LC and QMRP 1, #2 and #4's Individual of not have objectives for eachs. No further was available for review. The LC and QMRP 1, #2 and #4's Individual of not have objectives for eachs. No further was available for review.	W	0460	W460 483.480 Food and Nutiritic Services All sttafi att the sitte will receive rettraining on every individual's diettary requirementts and review each person's dining risk plans. Att leastt montthly observattons will be conductted by tthe Program Direct or designee tto assure thatt each is implementing the diettary plan Immediatte fieedback will be given the sttafi during those observatto. This will be documented on an Active Treattmentt Observatton fic A copy ofi those fiorms will be given to the Program Coordinattor fior review and fiollow up	t be sttafi s n tto ons orm	10/09/2011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G452	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/09/2011
	PROVIDER OR SUPPLIER		STREET A 52812 H	DDRESS, CITY, STATE, ZIP CODE HIGHLAND DR BEND, IN46635	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Plan" dated 8/15. "[Client #1] is presoft diet. All footonsistencyDry avoided. Nuts, refruit are amongstare of most risk, be avoided." An interview with conducted on 9/8 nurse indicated s	cated a "Dining Risk /11 which indicated: escribed a mechanical od should be a soft or chewy food should be aisins, grapes or crunchy a some of the foods that these should absolutely the nurse was 8/11 at 1:10 P.M The taff should ensure clients ecommended diets.		Systtem wide all Program Directto/QMRP's will review tthis sttandard and assure tthatt tthis concern is being addressed att a Dungarvin ICF-MR's. Persons Responsible: Program Directior(QMRP)	